State of Idaho, Division of Medicaid

UNIVERSAL PRIOR AUTHORIZATION FORM

*** CONFIDENTIAL INFORMATION ***

Phone: 1-208-364-1829 One drug per form ONLY – Use black or blue ink Fax: 1-208-364-1864

Patient Name:		Medicaid ID #:		Date of Birth:	
Prescriber Name:		State License #:		Specialty:	
Prescriber Phone:		Prescriber Fax:			
Pharmacy/Store #:		Pharmacy Phone:		Pharmacy Fax:	

Specific forms are available for Quantity Overrides or Brand Name Prior Authorizations on the website.

Reason for request (please check one):

☐ **AGE OVERRIDE**

→ *For age override requests, please submit medical literature documenting the safety and efficacy in the age group requested.*

☐ **MEDICATION PRIOR AUTHORIZATION**

Medication Requested:

Drug: _____ Strength: _____ Dosage form: _____

Diagnosis: _____ ICD-9 code: _____ Dosing Instructions: _____

Prior Therapy/Trials:

Drug: _____ Strength: _____ Dosage form: _____

Dosing Instructions: _____

Reason(s) for failure: _____

Has patient had a medical consult? ☐ Yes (*if "yes" please attach consult*) ☐ No

Therapeutic Use Justification:

Please provide rationale and/or additional information (relevant chart notes, labs, etc.) which may aid in the prior authorization decision making process.

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date:	RPh:	Tech:	PA#:
Approved	Denied	Comments:	

All current PA forms and criteria for use are available at: http://www.medicaidpharmacy.idaho.gov (PA Criteria & Forms)

Rev: 8/30/06